

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9195

CERTIFICATE OF DEATH

Reg. Dist. No.

09163

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville (Locust Grove)		c. LENGTH OF STAY IN lb 10 YRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Kennedyville, Md.	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HOPE		First CALDWELL	Middle COPPER
4. DATE OF DEATH August 6	Month 1959	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 8, 1876
9. AGE (In years lost birthday) 82 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	11. KIND OF BUSINESS OR INDUSTRY Farm	12. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME JOHN FRANK COPPER	14. MOTHER'S MAIDEN NAME SUSAN WATTS	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 217-12-40348		17. INFORMANT Mrs. Mildred Cleaver	Address Kennedyville, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 610X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Prostatism DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Cardiovascular disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour: o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1</u> , 1959, to <u>August 6</u> , 1959, that I last saw the deceased alive on <u>August 6</u> , 1959, and that death occurred at <u>5:00 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Robert W. Farr</u> PHYSICIAN'S NAME (Type) <u>Robert W. Farr</u>		ADDRESS (Street, city or town, state) DATE SIGNED Chestertown, Md., 6 August 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8-9-59	22c. NAME OF CEMETERY OR CREMATORIUM CHURCH HILL CEMTY	22d. LOCATION (City, town, or county) (State) CHURCH HILL MD.
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u>	ADDRESS STILL POND, MD.	24a. REC'D BY REGISTRAR DATE AUG 7 '59	24b. REGISTRAR'S SIGNATURE <u>Caroline S. Krause</u>

FOR STATE
HEALTH DEPT.

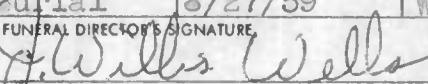
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9196 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09164

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake Bay near Rock Hall, Md.			c. LENGTH OF STAY IN 1b nr. Rock Hall			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS Piney Neck			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) James Lemuel Crouch			First	Middle	Last	
4. DATE OF DEATH Aug. 23, 1959			Month	Day	Year	
5. SEX male			6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9, 1932	
9. AGE (In years last birthday) 27 yrs.			10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Contractor			10b. KIND OF BUSINESS OR INDUSTRY self employed			
11. BIRTHPLACE (State or foreign country) Kent Co. Maryland			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME G. Cecil Crouch			14. MOTHER'S MAIDEN NAME Helen Wood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 214-30-8415 17. INFORMANT Mrs. Helen W. Crouch Address Rock Hall, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 850X DUE TO Fell over board from boat in waters of the Chesapeake Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bay near Rock Hall, Md. at about 10:30 A.M. 8/23/59. DUE TO Body was recovered in same area about 8:00 A.M. 8/26 (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 8/23 1959			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chesapeake Bay Rock Hall			20f. (City or town) (County) (State) Kent Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE 			DATE SIGNED 8/27/59			
EXAMINER'S NAME (Type) Robert W. Farr			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/27/59	22c. NAME OF CEMETERY OR CREMATORIAL Wesley Chapel Cem.		22d. LOCATION (City, town, or county) (State) Rock Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE 			ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE	
			DATE AUG 28 '59	Cuthbert S. Keane		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 09165

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton RFD		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Coleman's Corner		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Worton RFD Coleman's Corner	
3. NAME OF DECEASED (Type or print) Linnington		4. DATE OF DEATH Aug. 4, 1959	
First	Middle	Last	Month Day Year Aug. 4, 1959
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/6/05
9. AGE (In years lost birthday) 54	10. IF UNDER 1 YEAR Months 5	11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Kent Co. Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Armor Dorsey		14. MOTHER'S MAIDEN NAME Beulah Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 222-03-1349 17. INFORMANT Beulah Jackson Worton, Md. Rfd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 444X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 5 min.	
(b) <u>Atrial Fibrillation</u> DUE TO and (c) <u>Hypertension</u>		2 years 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Occlusion April 1959		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 5/1958</u> , to <u>August 4, 1959</u> , that I last saw the deceased alive on <u>August 4, 1959</u> , and that death occurred at <u>8 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Florence D. Joyce M.D. Worton, Md.			
ACTUAL SIGNATURE		DATE SIGNED	
PHYSICIAN'S NAME (Type) Florence D. Joyce		Worton, Md. RFD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/9/59	
22c. NAME OF CEMETERY OR CREMATORIAL Coleman's Cemetery		22d. LOCATION (City, town, or county) Worton, Md. RFD	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Waller		24a. REC'D BY REGISTRAR DATE AUG 10 '59	
ADDRESS Chestertown, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

CERTIFICATE OF DEATH

Name of deceased		Name of physician	
John Doe		Dr. John Smith	
Age at death		Cause of death	
65 years		Diseased heart	
Place of death		Name of hospital	
Home		None	
Date of birth		Date of death	
1880		1945	
Place of burial		Name of funeral home	
Cemetery		None	
Signature of physician		Signature of deceased	
Dr. John Smith		John Doe	
Signature of registrar		Signature of witness	
John Doe		John Smith	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09166

9198

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Locust Grove		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Locust Grove, Rural Kennedyville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First HARRY	Middle R.	Lost GARY	4. DATE OF DEATH	Month August	Day 25,	Year 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH July, 11, 1868	9. AGE (In years 91 1st birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mason		10b. KIND OF BUSINESS OR INDUSTRY Brick Work		11. BIRTHPLACE (State or foreign country) Del.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James H. Gary			14. MOTHER'S MAIDEN NAME Mary V. Price					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 213-24-1026			17. INFORMANT Mrs. Della Bickling, Chestertown, Md.		
Address								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 DUE TO Hemorrhage								
INTERVAL BETWEEN ONSET AND DEATH 4: - hrs								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) Cancer of Lip & Throat			(c) Hearb		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May</u> , 19 <u>59</u> , to <u>August 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug 25</u> , 19 <u>59</u> , and that death occurred at <u>20</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>L.P. Atwell</u>			ADDRESS (Street, city or town, state) <u>Still Pond, Md.</u>					
PHYSICIAN'S NAME (Type) Dr. L.P. Atwell			DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 28, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Galena Cemetery		22d. LOCATION (City, town, or county) Galena, Kent Co.		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows, Wellington, Md.</u>			ADDRESS <u>18</u>		24a. REC'D BY REGISTRAR DATE AUG 31 '59		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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CERTIFICATE OF DEATH

Date of Birth

Cause of Death

Place of Death

Name of Hospital

Name of Doctor

Name of Mortician

Name of Coroner

Name of Sheriff

Name of Clerk

Name of Sheriff

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9192 CERTIFICATE OF DEATH

Reg. Dist. No. 09167

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hospital (1 day)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Grover C. Hadaway		4. DATE OF DEATH Aug. 22, 1959	Month Day Year Aug. 22, 1959
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/8/84
9. AGE (In years at death) 74 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Retired Meat Cutter (Retail)	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country) Kent Co. Maryland
13. FATHER'S NAME Thomas B. Hadaway	14. MOTHER'S MAIDEN NAME Mary Brown	12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no. or unknown) no	16. SOCIAL SECURITY NO. 217-20-3176	17. INFORMANT Mrs. Muriel Hadaway	Address Mill St. Chestertown, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/22, 1959, to 8/22, 1959, that I last saw the deceased alive on 8/22, 1959, and that death occurred at 6 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 2/24/59			
ACTUAL SIGNATURE <i>Robert W. Farr</i>	PHYSICIAN'S NAME (Type) Robert W. Farr M. D. Chestertown, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/25/59	22c. NAME OF CEMETERY OR CREMATORIUM Chester Cemetery	22d. LOCATION (City, town, or county) (State) Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Willis Wells</i>		ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR DATE AUG 26 '59
			24b. REGISTRAR'S SIGNATURE <i>Arthur L. Trahan</i>

81 PRO-ROCK—KICKIN' TO THE MAX 80'S RAP 90'S RAP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9193

CERTIFICATE OF DEATH

Reg. Dist. No. 09168

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevensville	
3. NAME OF DECEASED (Type or print) William Lee		First William	Middle Lee
4. DATE OF DEATH 8 24 1959		5. SEX Male	6. COLOR OR RACE White
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 3/17/81	
9. AGE (In years last birthday) yrs. 78		10. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Lee Hope		14. MOTHER'S MAIDEN NAME Lula ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Son, Lee Hope, Fred		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central Vascular Accident DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/23 , 1959, to 8/24 , 1959, that I last saw the deceased alive on 8/23 , 1959, and that death occurred at 8/24 , 1959, M, from the causes and on the date stated above. ACTUAL SIGNATURE William M. Patterson M.D. PHYSICIAN'S NAME (Type) Rock Hall		20g. ADDRESS (Street, city or town, state) 8/24/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/27/59	
22c. NAME OF CEMETERY OR CREMATORIUM Kings Mountain		22d. LOCATION (City, town, or county) Kings Mountain NC	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar S. Lane		24a. REC'D BY REGISTRAR DATE SEP 9 '59	
ADDRESS Church Hill Md		24b. REGISTRAR'S SIGNATURE Edgar S. Lane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9199

CERTIFICATE OF DEATH

09163

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Kent			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Kent		
CITY (If outside corporate limits, write RURAL OR TOWN Betterton In Car			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chestertown (Lifetime)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS X In car while visiting at Betterton			STREET ADDRESS High St.		
3. NAME OF DECEASED (First) Etta (Middle) Cooper (Last) Robinson			4. DATE (Month) (Day) (Year) OF DEATH Aug. 30, 1959		
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH July 5, 1888	9. AGE last birthday 71	IF UNDER 1 YEAR Months Days Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Kent Co. Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Samuel E. Cooper			14. MOTHER'S MAIDEN NAME Margaret A. Patrick		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No			16. SOCIAL SECURITY NO. no		
17. INFORMANT & ADDRESS Mrs. Hallie Simpson			18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) VENTRICULAR FIBRILLATION ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Chronic left sided coronary insufficiency 3 yrs GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (C) antero-lateral myocardial infarct 3 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 5 Minutes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lectory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 1955, to August 1959, that I last saw the deceased alive on August 21, 1959, and that death occurred at 4:45 A.M. from the causes and on the date stated above. SIGNATURE Florence d. Joyce M.D.					
23. BURIAL, CREMATION, REMOVAL (SPECIES) Burial		DATE THEREOF Sept. 2, 1959		NAME OF CEMETERY OR CREMATORIAL Chester Cam.	
24. REC'D BY REGISTRAR DATE SEP 1 '59		REGISTRAR'S SIGNATURE Carrie S. Knott		LOCATION (City, town, or county) Chestertown, Md.	
25. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells				ADDRESS Chestertown, Md.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9200

CERTIFICATE OF DEATH

Reg. Dist. No. 09170

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown RURAL		c. LENGTH OF STAY IN 1b RFD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chestertown RFD	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Albert	Middle Scott
4. DATE OF DEATH Aug. 16, 1959		Month Aug.	Day 16
5. SEX male		6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH July 4, 1876		9. AGE (In years lost birthday) 83 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Laborer	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs. Lula Scott
		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 794X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO lying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH One month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 8</u> , 1959, to <u>Aug 7</u> , 1959, that I last saw the deceased alive on <u>Aug 6</u> , 1959, and that death occurred at <u>2 a. M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Rock Hall, Md. DATE SIGNED 8/17/59	
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Eugene Kester		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/19/59	22c. NAME OF CEMETERY OR CREMATORIAL Georgetown Cem.
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Wallace		24a. ADDRESS Chestertown, Md.	24b. REC'D BY REGISTRAR DATE AUG 19 59
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 X
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

VS. AT 5ME
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09171

1. PLACE OF DEATH a. COUNTY KENT	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Kent					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WORTON (Rural)	c. LENGTH OF STAY IN 1b 30 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton, Rural					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Andelot Farm	d. STREET ADDRESS Andelot Farm	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ANNA E	First LOUISE	Middle THORNTON	4. DATE OF DEATH Aug 3 1959	Month Aug	Day 3	Year 1959	
5. SEX Female	6. COLOR OF RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug 24, 1887	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Alonzo Boulder	14. MOTHER'S MAIDEN NAME Rosa Simpson						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 222-20-20703	17. INFORMANT Eugene Thornton, Worton, Md.	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arterial hypertension							
INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1b or Part 20a if item 20a is checked) Had had no doctor for 3-4 yrs. No apparent good health except for severe nocturnal alpraxia shortness of breath, pain in chest, nausea & died 1/2 hours later						
20c. TIME OF INJURY Hour 10:00	Month, Day Aug 5	20d. INJURY OCCURRED While Not while	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Worton, Md.				
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> at 2:55 am.							
ACTUAL SIGNATURE Robert W. Farr	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED 8/3/59
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug 5/59	22c. NAME OF CEMETERY OR CREMATORIAL Bethel Cemetery	22d. LOCATION (City, town, or county) Chesapeake City, Md.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Marvin K. Williams - Chesapeake Md.	ADDRESS Chesapeake City, Md.	24a. REC'D BY REGISTRAR Aug 5 '59	24b. REGISTRAR'S SIGNATURE Carlton S. Thomas				

WISCONSIN STATE APPROVALS OF MEDICAL EXAMINERS CERTIFICATE OF DEATH

STATE 2013
1-12-2013

I certify that the deceased person died in the state of Wisconsin.

I certify that the deceased person died in the city of Milwaukee.

I certify that the deceased person died in the county of Milwaukee.

I certify that the deceased person died in the state of Wisconsin and in the city of Milwaukee.

I certify that the deceased person died in the state of Wisconsin and in the county of Milwaukee.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9194

CERTIFICATE OF DEATH

Reg. Dist. No.

09172

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hospital Hours		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Mary Minta Vickers		4. DATE OF DEATH Aug. 4, 1959	Month Day Year 1959
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/19/80
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Startt		14. MOTHER'S MAIDEN NAME Copper Brook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	17. INFORMANT Hospital Records
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Startt	
DUE TO arteriosclerotic heart disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rock Hall, Md.
21. I certify that I attended the deceased from 8/4/59 to 8/4/59 , 19, that I last saw the deceased alive on 8/4/59 at 2 PM , and that death occurred at 2:45 PM , from the causes and on the date stated above.		20f. (City or town) (County) (State)	
ACTUAL SIGNATURE William M. Gatewood		ADDRESS (Street, city, or town, State) Rock Hall, Md.	
PHYSICIAN'S NAME (Type) William M. Gatewood		DATE SIGNED 8/6/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/7/59	22c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery	22d. LOCATION (City, town, or county) Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		24a. REC'D BY REGISTRAR DATE AUG 10 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

81 39051-5744-0 SUBMITTING STATE CHARTER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09173

FOR STATE
HEALTH DEPT.
M

9202

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1.		PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
a. COUNTY		Kent MARYLAND		a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Millington				Millington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First JOHN	Middle LEE	Last WARNER	4. DATE OF DEATH August 9 1959
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 30, 1927	9. AGE (in years last birthday) 32 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Charles E. Warner		14. MOTHER'S MAIDEN NAME Ida J. Pratt		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes WW 2		16. SOCIAL SECURITY NO.		17. INFORMANT Address Charles E. Warner (Father) Millington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Convulsive seizure Sub-dural hemorrhage <small>INTERVAL BETWEEN ONSET AND DEATH short</small>					
237X DUE TO Probable Chronic Brain Syndrome several years					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Alcoholism Tumor left temporal lobe several years					
Had been on an alcoholic binge for about a week. In the past 4 (c) or 5 years, had been subject to generalized seizures when drink					
ings. Was apparently well when left alone at about 10:30 AM and was found dead, was autopsy performed? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20d. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Robert W. Farr		August 9, 1959			
22e. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG. 12, 1959		22c. NAME OF CEMETERY OR CREMATOR Y SUDLERSVILLE CEM.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows.		ADDRESS Wellington Rd.		24a. REC'D BY REGISTRAR DATE 14 1 '59	
				24b. REGISTRAR'S SIGNATURE Charles E. Warner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours for death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
19203 CERTIFICATE OF DEATH 09174

Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY Kent Still Pond MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Still Pond				c. LENGTH OF STAY IN 1b life							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION at home				e. STREET ADDRESS /							
3. NAME OF DECEASED (Type or print) Thomas				First	Middle	Last	4. DATE OF DEATH 8/5/59	Month	Day	Year 19	
5. SEX male		6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 26, 1900		9. AGE (In years last birthday) 58	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer at general store			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Thomas A. White			14. MOTHER'S MAIDEN NAME Carrie A. Johnson								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 17-12-4902			17. INFORMANT Mary White	Address Still Pond, Md. Box # 49				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Cancer of Liver Endocarditis											
INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Rheumatic											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m. no			Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Aug 7	(County) Kent	(State) Md.			
21. I certify that I attended the deceased from May 3, 1959, to Aug 5, 1959, that I last saw the deceased alive on Aug 5, 1959, and that death occurred at Aug 5, 1959, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Still Pond, Md.											
DATE SIGNED 8/6/59											
ACTUAL SIGNATURE L. P. Atwell											
PHYSICIAN'S NAME (Type) L. P. Atwell											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/8/59		22c. NAME OF CEMETERY OR CREMATORIUM Still Pond Cem.			22d. LOCATION (City, town, or county) (State) Still Pond, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Waller		ADDRESS Mt. Zion Chestertown, Md.			24a. REC'D BY REGISTRAR AUG 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan				

